Handbook for Providers of Optometric Services

Chapter O-200
Policy and Procedures for Optometric Services

Illinois Department of Public Aid

CHAPTER O-200

OPTOMETRIC SERVICES

TABLE OF CONTENTS

FOREWORD

O-200 BASIC PROVISIONS

O-201 PROVIDER PARTICIPATION
- .1 Participation Requirements
- .2 Participation Approval
- .3 Participation Denial
- .4 Provider File Maintenance
- .5 Therapeutic Pharmaceutical Agent (TPA)/Diagnostic Pharmaceutical Agent (DPA) Certification

O-202 PROVIDER REIMBURSEMENT
- .1 Charges
- .2 Electronic Claims Submittal
- .3 Claim Preparation and Submittal
  - .31 TPA/DPA Certified Optometrists
  - .32 Non-TPA/DPA Certified Optometrists
  - .33 Opticians and Optical Companies
  - .34 Claims Submittal
- .4 Payment

O-203 COVERED SERVICES
- .1 Examination to Determine the Condition of the Eye Including the Refractive State
- .2 Dispensing Fee
- .3 Service Fee
- .4 Medical Services Provided by TPA/DPA Certified Optometrists
- .5 Early Intervention Services

O-204 NON-COVERED SERVICES

O-205 RECORD REQUIREMENTS

O-210 GENERAL LIMITATIONS AND CONSIDERATIONS ON COVERED MEDICAL DIAGNOSTIC AND TREATMENT SERVICES

O-211 PRIOR APPROVAL PROCESS

O-212 LIMITATIONS AND CONSIDERATIONS ON SPECIFIC ITEMS
- .1 Lenses
- .2 Contact Lenses
- .3 Custom-made Artificial Eyes
- .4 Low Vision Devices
- .5 Fabrication of Glasses by Suppliers Other than DOC
- .6 Items Not Otherwise Identified
- .7 Frequency of Services

O-220 OFFICE SERVICES (TPA/DPA)

O-221 PHARMACY ITEMS (TPA/DPA)

O-235 PROVISION OF EYEGLASSES AND OPTICAL MATERIALS
- .1 Ordering of Frame Boards
- .2 Ordering of Eyeglasses
- .3 Quality Assurance
- .4 Replacement of Broken Lenses
- .5 Frame, Frame Parts and Repairs

O-270 HOME AND LONG TERM CARE FACILITY SERVICES
- .1 Long Term Care Facility Limitations And Requirements - Vision Examinations And Refractions
- .2 Long Term Care Facility Limitations And Requirements - Medical Services Provided by a TPA/DPA Certified Optometrist

O-283 SURGICAL SERVICES

APPENDICES

Appendix O-1	**Claim Preparation And Mailing Instructions For Form DPA 1443, Provider Invoice**
Appendix O-1a	**Form DPA 1443, Provider Invoice**
Appendix O-1b	**Form DPA 2803, Optical Prescription Order**
Appendix O-1c	**Preparation and Mailing Instructions For Medicare/Medicaid Combination Claims**
Appendix O-2	**Procedure Codes Billable by Opticians And Optical Companies**
Appendix O-3	**Vision Care Procedure Codes Billable by All Optometrists**
Appendix O-4	**Additional Procedure Codes Billable by TPA/DPA Certified Optometrists Only**
Appendix O-5	**Preparation And Mailing Instructions For Form DPA 1409, Prior Approval Request**
Appendix O-5a	**Form DPA 1409, Prior Approval Request**
Appendix O-6	**Explanation of Information on Provider Information Sheet**
Appendix O-6a	**Provider Information Sheet**

FOREWORD

This handbook has been prepared for the information and guidance of opticians, optical companies, optometrists and ophthalmologists who provide vision care services for participants in the Department's Medical Programs. It also provides information for opticians, optical companies and optometrists on the Department's requirements for provider participation and enrollment.

Limited guidance is contained in this handbook for the provision of medical diagnostic and therapeutic services for the eyes. Additional guidance for such medical services, whether provided by optometrists or by physicians, can be found in the Handbook for Physicians, Chapter A-200.

= This handbook can be viewed on the Department's website at

http://www.state.il.us/dpa/handbooks.htm

This handbook provides information regarding specific policies and procedures relating to optometric services.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The updates will be posted to the Department's website at

http://www.state.il.us/dpa/medical_programs.htm

Providers will be held responsible for compliance with all policy and procedures contained herein.

CHAPTER O-200

OPTOMETRIC SERVICES

O-200 BASIC PROVISIONS

= For consideration for payment by the Department for optometric services, such services must be provided by an optometrist, ophthalmologist, optician or optical company enrolled for participation in the Department's Medical Programs. Services provided must be in full compliance with both the general provisions contained in the Handbook for Providers of Medical Services, Chapter 100, General Policy and Procedures (Chapter 100) and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

O-201 PROVIDER PARTICIPATION

O-201.1 PARTICIPATION REQUIREMENTS

An optometrist who holds a valid Illinois (or state of practice) license to practice optometry is eligible to be considered for enrollment to participate in the Department's Medical Programs.

- Optometrists holding non-teaching administrative or staff positions in schools or other institutions may be approved for participation in the provision of direct services if they maintain a private practice.

- Teaching optometrists who provide direct services may be approved for participation provided that salaries paid by schools or other institutions do not include a component for treatment services.

No license is required for enrollment as an optician or optical company, but the provider must be in compliance with relevant state laws in the state in which he is doing business.

Participation requirements for ophthalmologists are covered in the Handbook for Physicians. See Topic O-202.31 for instructions on obtaining a Handbook for Physicians.

The provider must be enrolled for the specific category of service for which charges are to be made.

The categories of service for which an optometrist may enroll are:

- Category 01 - Physician Services (Therapeutic Pharmaceutical Agent (TPA)/Diagnostic Pharmaceutical Agent (DPA) only)
- Category 03 - Optometric Services
- Category 45 - Optical Materials

Opticians and Optical Companies may only enroll for Category of Service 45 - Optical Materials.

Procedure: The provider must complete and submit:

- Form DPA 2243 Provider Enrollment/Application
- Form DPA 1413 Agreement for Participation
- W9 Request for Taxpayer Identification Number

These forms may be obtained from the Provider Participation Unit. E-mail requests for enrollment forms should be addressed to:

PPU@mail.idpa.state.il.us

Providers may also call the unit at (217)782-0538 or mail a request to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

= The forms must be completed (**printed** in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the provider requests a specific enrollment date.

O-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix O-6.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to insure that all identifying information required is an exact match to that in the Department file. If any of the information is incorrect, refer to Topic O-201.4.

O-201.3 PARTICIPATION DENIAL

When participation is denied, the provider will receive written notification of the reason for denial.

= Within ten calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

O-201.4 PROVIDER FILE MAINTENANCE

The information carried in Department files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

= The information contained on the Provider Information Sheet is that which is carried on Department files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the Department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified. When possible, notification should be made in advance of a change.

Procedure: The provider is to line out the incorrect or changed data, enter the correct data, date and sign the Provider Information Sheet on the line provided with an original signature. Forward the corrected Provider Information Sheet to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify the Department of corrections and/or changes may cause an interruption in participation and payments.

Department Responsibility

= When there is a change in a provider's enrollment status or a change is submitted by the provider, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

O-201.5 TPA/DPA CERTIFICATION

Optometrists who have received Diagnostic Pharmaceutical Agents (DPA) or Therapeutic Pharmaceutical Agents (TPA) certification from the Illinois Department of Professional Regulation may receive reimbursement for a greater range of services than non-certified optometrists. To qualify for this reimbursement, optometrists must mail or fax a copy of their license indicating the certification to the Department. They should also provide their Medicare Provider Number, if applicable. The mailing address and fax number are:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Fax number: (217) 557-8800 Attn: PPU

The Department will mail to the optometrist a copy of the Provider Information Sheet reflecting the certification status. Upon receipt of the updated Provider Information Sheet, the optometrist may begin submitting claims.

O-202 PROVIDER REIMBURSEMENT

The Department uses the Illinois Department of Corrections (DOC) for fabrication of eyeglasses. Optometrists will be reimbursed for professional services and, if appropriate, a dispensing fee for eyeglasses. Except as provided in Topic O-212.5, providers will not be reimbursed for the fabrication or sale of eyeglasses.

When billing for services or materials or both, the claim submitted for payment must include a description of the actual services provided or the materials dispensed. Any payment received from a third-party payer, a program participant or other persons incident to examination or provision of glasses must be reflected as a credit on any claim submitted to the Department bearing charges for covered services.

There are to be no arrangements to furnish more costly products such as more expensive frames or tinted lenses, etc., with the patient supplementing charges made to the Department.

O-202.1 CHARGES

Charges made to the Department are to be the provider's usual and customary charges to the general public for the services provided.

Providers may charge only for services they personally provide, or which are provided under their direct supervision in their offices by their staff, e.g., dispensing done by a technician in a provider’s employ.

A provider may not charge, however, for services provided by another provider even though one may be in the employ of the other.

Providers may not charge for services provided outside their offices by anyone other than themselves.

Allowable Charges By Teaching Optometrists

Teaching optometrists who provide direct patient care may submit charges for the services provided, if the salary paid them by the school or other institution does not include a component for treatment services.

Charges are to be submitted only when the teaching optometrist seeking reimbursement has been personally involved in the services being provided. This means presence in the room performing or supervising the major phases of the services with full and immediate responsibility for all actions performed as a part of the

testing or examination. The patient's record must be documented to show these requirements have been met. All such entries must be signed and dated by the optometrist seeking reimbursement.

O-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services which do not require attachments or accompanying documentation may be billed electronically. Further information can be found in Chapter 100, Topic 112.3.

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Providers billing electronically should take special note of the requirement that Form DPA 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three years. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form DPA 194-M-C can be found on the last page of each Remittance Advice which reports the disposition of any electronic claims. Refer to Handbook for Providers of Medical Services, Chapter 100 General Policies and Procedures, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

O-202.3 CLAIM PREPARATION AND SUBMITTAL

See Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, see Chapter 100, Topics 112.5 and 120.1. For specific instructions on preparation of claims for Medicare covered services, refer to Appendix O-1c.

= The Department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix O-1 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scannability/imaging evaluation. Please send sample claims with a request for evaluation to the following address.

Illinois Department of Public Aid
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

O-202.31 TPA/DPA Certified Optometrists

Optometrists who have supplied the Department with proof of their TPA/DPA certification may bill and be reimbursed for medically-necessary diagnostic and treatment services related to conditions of the eye. A complete list of billable services is contained in Appendices O-3 and O-4.
All of the procedures listed in Appendix O-4 should be billed using the Health Insurance Claim Form DPA 2360. For instructions on completing Form DPA 2360, see Appendix A-1 of the Department's Handbook for Physicians, Chapter A-200.

Copies of the Handbook for Physicians may be downloaded from the Department's website at http://www.state.il.us/dpa/

Copies may also be obtained by contacting the Provider Participation Unit at:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

E-mail: PPU@mail.idpa.state.il.us
Fax number: (217) 557-8800 Attn: PPU

For CPT codes listed in Appendix O-4 and billed by a TPA/DPA certified optometrist, an ICD-9-CM diagnosis code indicating an eye-related diagnosis is required in section D of item 24 of Form DPA 2360.

CPT codes are not to be used to bill for routine eye examinations to determine visual acuity and the refractive state of the eyes or for dispensing fees. Continue to bill these services on Form DPA 1443, Provider Invoice, as described in Topic O-202.32 below.

O-202.32 Non-TPA/DPA Certified Optometrists

Form DPA 1443, Provider Invoice, is to be used to submit charges for covered services provided by optometrists who are not TPA or DPA certified. A copy of the Form DPA 1443 and detailed instructions for completion are included in Appendices O-1 and O-1a.

All services for which charges are made are to be coded on Form DPA 1443 with specific procedure codes as described in Appendix O-3. No other procedure codes are acceptable. Reimbursement will not be made for services provided when the claim has been completed with invalid procedure codes.

O-202.33 Opticians and Optical companies

Form DPA 1443, Provider Invoice, is to be used to submit charges for covered services provided by opticians and optical companies. A copy of Form DPA 1443 and detailed instructions for completion are included in Appendices O-1 and O-1a.

All services for which charges are made are to be coded on Form DPA 1443 with specific procedure codes as described in Appendix O-2. No other procedure codes are acceptable. Reimbursement will not be made for services provided when the claim has been completed with invalid procedure codes.

O-202.34 Claims Submittal

All routine paper claims, including those with an Optical Prescription Order (OPO) form attached, are to be submitted in a pre-addressed mailing envelope provided by the Department for this purpose, Form DPA 1444, Provider Invoice Envelope. Routine claims with an OPO attached and routine claims with no OPO attached should be mailed in separate envelopes. Using the pre-addressed envelopes and separating claims as described above should insure that claim forms will be properly routed for processing.

= For a non-routine claim submittal, use Form DPA 2248, Special Handling Envelope. A non-routine claim is:

- Any claim to which Form DPA 1411, Temporary MediPlan Card, is attached.
- Any claim to which a document other than the OPO is attached.

For electronic claims submittal, see Topic O-202.2 above. Non-routine claims and claims with an OPO attached may not be electronically submitted.

O-202.4 PAYMENT

= Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department. Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the Department and General Appendix 8 for explanations of Remittance Advice detail provided to providers.

Reimbursement for Vision Examinations

The reimbursement made for the vision examination to determine the condition of the eye includes all services provided during the examination and associated vision care services provided as a result of examination findings, such as the writing of an Optical Prescription Order (OPO).

Reimbursement for Medical Services

When an initial medical office visit and a procedure are provided for a new patient on the same day, each service may be payable at the rate described earlier in this Topic. On subsequent medical visits when a procedure is performed the same day, the provider may bill both, but the Department's total payment will be capped. In calculating the cap, the Department compares the maximum rate payable for each service billed and selects the highest amount payable.

Reimbursement for Contact Lenses

Except lenses for aphakic children under the age of three, coverage of contact lenses is subject to prior approval. Refer to Topic O-212.2.

The reimbursement made for contact lens services includes the carrying case, appropriate solutions and equipment, verification and inspection of lenses, all studies made including time spent to advise the patient in care and in use of the lenses (subsequent office visits and consultations to achieve maximum wearing time) and any modifications of lenses during the adaptation period.

The payment for contact lenses for aphakic children will be based upon the acquisition cost to the provider. The acquisition cost is defined as the actual amount the supplying provider must pay to acquire the contact lens(s), taking into account any discounts, rebates or bonuses and including all freight, postage, delivery and demurrage. Patient records should document acquisition costs.

O-203 COVERED SERVICES

A covered service is a service covered under the Department's Medical Programs and for which payment can be made by the Department. The services covered in the program are limited and include only those reasonably necessary medical and remedial services which are recognized as standard medical care required for immediate health and well-being because of illness, disability, infirmity or impairment. See Appendices O-2, O-3 and O-4 for a list of services covered in the program and for procedure codes to be used when billing for services provided or materials dispensed.

> Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics in this handbook.

The provision of glasses and other materials which are required to restore and conserve vision are a covered service. All lenses and frames are to be obtained from the Department of Corrections (DOC) laboratory.

> Optical Prescription Order (OPO) forms are to be attached to the claim form for the vision exam or dispensing fee. The Department will forward the OPO to DOC. Reimbursement for the lenses and frames will be made by the Department directly to DOC.

The provider may bill the Department for an examination and dispensing fee. A provider may also provide frame parts, frame repairs, contact lenses, artificial eyes and low vision devices. Some of these services are subject to prior approval, as described in Topic O-211.

Any question a provider may have about coverage of a particular service is to be directed to the Department prior to provision of the service. Providers may call the Bureau of Comprehensive Health Services at 217-782-5565.

O-203.1 EXAMINATION TO DETERMINE THE CONDITION OF THE EYE INCLUDING THE REFRACTIVE STATE

Optometrists may receive payment for eye examinations only when the services have been requested because of an identified problem. Routine periodic examinations are not covered by the Department. The Department provides for no more than one examination in a 12-month period. If more frequent care is medically

necessary because of an unusual circumstance, the patient's record must be documented with an explanation of the special circumstances and of the services provided.

The eye examination must be conducted in accordance with Rules promulgated by the Illinois Department of Professional Regulation implementing the Illinois Optometric Practice Act 68 Ill.Admin.Code Part 1320. Those Rules list the following procedures as comprising a minimum eye examination:

1. Complete case history.
2. Visual acuity at distance.
   a. Unaided (mono plus binocular)
   b. Last prescription or habitual prescription (mono plus binocular).
3. External examination, including pupil reactivity.
4. Internal examination (ophthalmoscopic examination).
5. Retinoscopy.
6. Measurement of vergences and accommodation.
7. Measurement of phoric posture (far and near).
8. Subjective refraction.
   a. To best visual acuity at distance.
   b. To best visual acuity at near.
9. Measurement of binocularity.
10. Color vision screening.
11. Glaucoma screening with tonometry.

O-203.2 DISPENSING FEE

A charge may be made when eye care materials are to be dispensed if it is the provider's usual and customary practice to make such a charge. The charge is to be no more than that made by the provider to private pay patients and is to cover the fitting and subsequent adjustment services.

O-203.3 SERVICE FEE

A service fee may be charged when the dispensing fee is not applicable, e.g., when replacement parts are provided.

A service fee is not to be charged in combination with a dispensing fee.

O-203.4 MEDICAL SERVICES PROVIDED BY TPA/DPA CERTIFIED OPTOMETRISTS

TPA/DPA certified optometrists may bill and be reimbursed for certain medically-necessary diagnostic and treatment services related to conditions of the eye. A complete list of billable services is contained in Appendix O-4. Policies and procedures for these medical diagnostic and treatment services performed by TPA/DPA certified optometrists can be found in the Handbook for Physicians, Chapter A-200.

See Topic O-202.31 for instructions on obtaining a Handbook for Physicians.

TPA/DPA optometrists should familiarize themselves with any Topic in the Handbook for Physicians that applies to their particular practice focus.

When providing medical diagnosis or treatment to patients who are enrolled with a Managed Care Organization (MCO), optometrists must obtain authorization from the MCO. Payment for the authorized service must be sought from the authorizing entity.

The standard optometric services listed in Appendix O-3 are covered without regard to MCO enrollment of the patient.

O-203.5 EARLY INTERVENTION SERVICES

Early Intervention (EI) services are covered only for children up to the age of three years, who are eligible for Part H services under the Individuals with Disabilities Education Act and when those services are included in the child's Individualized Family Service Plan. Procedure codes for EI services must be billed to the EI Central Billing Office (CBO) for payment. In order to receive payment from the CBO, a provider must apply for and obtain an Early Intervention Credential, enroll as a provider with the CBO, and have prior authorization to provide services.

- For credential and enrollment information, contact Provider Connections at 1-800-701-0995.
- For questions about the service authorization and billing processes, contact the Early Intervention CBO Cornerstone Call Center at 1-800-634-8540.

O-204 NON-COVERED SERVICES

Services for which medical necessity is not clearly established are not covered in the Department's Medical Programs. Also see Chapter 100, Topic 104, for a list of services and supplies for which payment will not be made.

In addition, the following optometric services are excluded from coverage in the Department's Medical Programs and payment will not be made for the provision of these services:

- routine screenings
- routine periodic exams in the absence of an identified problem
- examination required for the determination of disability or incapacity. (Local Department of Human Services offices may request that such examinations be provided with payment authorized from nonmedical funds. Optometrists are to follow specific billing instructions given when such a request is made.)
- Services provided in federal or state institutions

O-205 RECORD REQUIREMENTS

= The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to Chapter 100, Topic 110 for record requirements applicable to all providers.

Providers must maintain an office record for each patient. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the individual optometrist, physician or optician rendering services.

The record maintained by the provider is to include the essential details of the patient's condition and of each service or material provided. Any services provided a patient by the provider outside the provider's office are to be documented in the medical record maintained in the provider's office. All entries must include the date and must be legible and in English. Records which are unsuitable because of illegibility or because they are written in a language other than English may result in sanctions if an audit is conducted.

For patients who are in a nursing facility, the primary medical record indicating the patient's condition and treatment and services ordered and provided during the period of institutionalization may be maintained as a part of the facility chart; however, an abstract of the facility record, including diagnosis, treatment program, dates and times services were provided, is to be maintained by the provider as an office record to show continuity of care.

Opticians and optical companies must maintain records adequate to document items dispensed and services provided, and to document that eyeglasses and other eye care materials are dispensed only in accordance with a prescription written by a physician or an optometrist.

The Department and its professional advisors regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are a key document for post payment audits.

> In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

O-210 GENERAL LIMITATIONS AND CONSIDERATIONS ON COVERED MEDICAL DIAGNOSTIC AND TREATMENT SERVICES

Medical diagnostic and treatment services performed by TPA/DPA certified optometrists are subject to the policies and procedures that are applicable to the same services when performed by physicians. These policies and procedures can be found in the Handbook for Physicians. See Topic O-202.31 for instructions on obtaining a Handbook for Physicians.

While the most common of these service situations have been highlighted in this handbook, not all have been explicitly referenced. TPA/DPA certified optometrists should therefore familiarize themselves with any Topic in the Handbook for Physicians that applies to their particular practice focus.

O-211 PRIOR APPROVAL PROCESS

Prior to the provision of certain services, and/or dispensing of certain materials, approval must be obtained from the Department.

If charges are submitted for services which require prior approval and approval was not obtained, payment will not be made for services as billed.

See Chapter 100, Topic 111, for a general discussion of prior approval provisions. Specific information required for each type of service or item is provided below.

Medicare Exception: An exception to the prior approval requirements exists in situations in which services or materials requiring prior approval are provided to a patient eligible for Medicare Part B benefits and the service or material is covered in the Medicare program. Prior approval requirements are waived in instances in which Medicare payment is **approved**.

If the service or material is denied by Medicare as non-covered or not medically necessary, post approval from the Department may be requested. Information to be submitted with the request is to include a complete description of the service or item.

When post approval is received, the provider is to submit a Provider Invoice (Form DPA 1443 or Form DPA 2360, as appropriate) with the Medicare Explanation of Benefits attached.

The Department will not give prior approval for an item or service if a less expensive item or service is considered appropriate to meet the patient's need.

Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service.

The approval to provide the service does not include approval of the amount to be paid unless the Department specifies an amount with the approval. The provider and the patient will be advised by the Department of approval or disapproval of the prior approval request.

The following services and materials may be provided only with prior approval of the Department:

- Contact lens/lenses and related service
- Custom made artificial eye
- Low vision devices
- Eyeglasses fabricated by suppliers other than DOC
- Service/materials not otherwise identified on the schedule of procedures for optical services and supplies

Refer to Appendices O-2 and O-3 for the billing codes of the vision care services which require prior approval.

Procedure: Prior approval to dispense or provide the above described service or material is to be requested by the provider using Form DPA 1409, Prior Approval Request. See Appendix O-5 for instructions for completing Form DPA 1409. Requests may be mailed to the Department in the Form DPA 2300, Prior Approval Request Envelope. Requests may also be faxed to the optometric prior approval unit at (217)524-7120.

When billing for a service or material which has been approved for a patient, the claim is to be submitted to the Department as a routine claim.

O-212 LIMITATIONS AND CONSIDERATIONS ON SPECIFIC ITEMS

O-212.1 LENSES

Single Vision Lenses

Lenses are covered only if the power is at least ± 0.75 diopters in either the sphere or cylinder component.

A change of lenses is a covered service only when there is a change of at least ±0.75 diopters in either the sphere or cylinder component.

Bifocal Lenses

Bifocal lenses are covered only if the power of the bifocal addition is ± 1.00 diopter or more. A change in lenses is covered if the distance power meets the minimum change requirements (± 0.75 diopters) or if the power of the bifocal addition is changed by at least ± 0.50 diopters.

Change From Single Vision to Bifocal or Bifocal to Single Vision

When changing from a single vision to bifocal, the distance component must meet the minimum prescription requirement (± 0.75 diopters) or the resultant total power of the new prescription must meet the requirement for a change in prescription (±0.75 diopters).

When changing from bifocal to single vision, the new prescription must meet the requirement for a change in prescription (± 0.75 diopters) figured from the resultant total power of the bifocal prescription and the new prescription must meet the minimum prescription power requirement (± 0.75 diopters).

O-212.2 CONTACT LENSES

Contact lenses require prior approval, except when provided to aphakic children age 0 to 3. Consideration will be given to approving contact lenses only when there is a documented medical need, a diagnosis of Monocular Aphakia, a pathological condition of the cornea or when useful vision cannot be obtained with glasses.

Requests for approval of contact lenses must include information explaining why the patient cannot be satisfactorily fitted with conventional lenses and a report of the patient's best spectacle lens prescription and the visual acuity achieved with contacts and with glasses. The request form must state whether the contact lenses are the patient's first contact lenses or replacements.

When contact lenses are approved, approval for glasses will not be given.

Contact lenses are covered for adults no more frequently than once per year.

Payment will be made for contact lens fitting service only when the approved lens or lenses are the patient's initial contact lens or lenses. Dispensing (Procedure Code X1015) is not a covered service when reimbursement is made for the fitting service (Procedure Code X1044/X1045).

O-212.3 CUSTOM-MADE ARTIFICIAL EYES

Custom-made artificial eyes are subject to prior approval and are covered only when the patient is unable to wear a stock plastic eye. All prior approval requests must include information as to why a stock artificial eye is not appropriate to meet the patient's need.

O-212.4 LOW VISION DEVICES

Prisms meeting the minimum power requirement do not require prior approval and may be prescribed when the medical need exists. The requirements are met only when the combined vertical prism power is at least ± 2 prism diopters or the combined horizontal prism power is at least ± 5 prism diopters.

Low vision devices other than eyeglasses and prisms are covered only with prior approval. Requests for prior approval to dispense low vision corrective devices must include information explaining in detail the patient's need for the device. Additionally, the request is to include the cost of the device, the life expectancy of the device and the manufacturer.

O-212.5 FABRICATION OF GLASSES BY SUPPLIERS OTHER THAN DOC

Fabrication of glasses by a supplier other than the Department of Corrections is covered only with prior approval. Requests for prior approval must include sufficient detail on the type of lens or frame to determine that they are not able to be manufactured by DOC. The request must also include information explaining why a standard pair of glasses is not medically appropriate to meet the patient’s need.

O-212.6 ITEMS NOT OTHERWISE IDENTIFIED

Services or materials which are not specifically identified in Appendices O-2, O-3 or O-4 require prior approval. Information must be submitted describing in detail the material or service to be provided. A history of past treatment provided is required. Additionally, the request for approval must show why the material or service is better

than any other commonly used to deal with similar diagnoses or conditions.

O-212.7 FREQUENCY OF SERVICES

Eyeglasses for adults are generally provided only once per year. However, a second pair of eyeglasses may be provided in the same year if the eyeglasses are lost or are broken beyond repair.

Replacement lenses are also generally provided only once a year. A second set of lenses may be provided in the same year if there is a change in the prescription which meets the requirements in Topic O-212.1 or if the lens or lenses are broken but the frame is still usable.

Refer to Topics O-235.4 and O-235.5 for policy and procedures for situations where either the lens or the frame requires replacement but the other is still usable.

If a third pair of eyeglasses or lenses is needed within the same year for any reason, prior approval is required. Refer to Topic O-211 for a description of the prior approval process.

O-220 OFFICE SERVICES (TPA/DPA)

The Handbook for Physicians, Topic A-220, Office Services, delineates general coverage, coding and documentation requirements and coverage restrictions for medical, diagnostic and treatment services provided in the office. These requirements are applicable to TPA or DPA or TPA/DPA certified optometrists.

When an optometrist shares a partnership or group practice with another optometrist or a physician, the same policies and billing limitations apply to all members in the same group practice. For example, a patient may be designated as a new medical patient for billing purposes only once collectively for all practitioners in the partnership or group, regardless of how many practitioners in the group practice eventually see the patient.

See Topic O-202.31 for instructions on obtaining a Handbook for Physicians.

O-221 PHARMACY ITEMS (TPA/DPA)

The Handbook for Physicians, Topic A-221, Pharmacy Items, delineates coverage, documentation requirements, coverage restrictions and prior approval requirements for pharmacy items prescribed or dispensed. These requirements are applicable to TPA or DPA or TPA/DPA certified optometrists who prescribe or dispense such items in the course of their practice.

See Topic O-202.31 for instructions on obtaining a Handbook for Physicians.

O-235 PROVISION OF EYEGLASSES AND OPTICAL MATERIALS

The optometrist or physician is to prescribe or dispense in accordance with the following requirements.

Glasses and other eye care materials may be dispensed or the optometrist or physician may give the necessary prescription to the patient to take to the participating optician of his choice. Opticians and optical companies may dispense eyeglasses and other eye care materials only when the provider has on file a prescription written by a physician or an optometrist.

O-235.1 ORDERING OF FRAME BOARDS

The Department utilizes the Department of Corrections (DOC) for fabrication of eyeglasses. DOC supplies a display board of the available eyeglass frames. There is a refundable deposit associated with this frame board, which is payable to DOC.

Procedure: Contact DOC at the following address and telephone number:

Dixon Correctional Facility Industries
Post Office Box 809
Dixon, Illinois 61021
Phone: 1-800-523-1487 (toll free)

O-235.2 ORDERING OF EYEGLASSES

The Optical Prescription Order (OPO), Form DPA 2803, is to be used to order lenses or frames or both. The OPO is to be attached to the back of the Provider Invoice and submitted to the Department of Public Aid in the usual manner for claim submittals. The Provider Invoice will show charges only for examination and dispensing fee, not lenses and frames. Upon receipt of these documents, the Department will enter the Provider Invoice into the Claims Processing System and forward the OPO for fabrication of eyeglasses to DOC. When the claim has completed normal editing for provider and patient eligibility and for previous eyeglasses utilization, the Department will instruct DOC to fabricate the eyeglasses. The eyeglasses will be mailed by DOC directly to the ordering provider. Eyeglasses are to be dispensed to the patient within a reasonable time period after receipt from DOC.

If the dispensing fee billed on the claim is not payable for any reason, the claim is rejected and the rejection is reported on the Remittance Advice. In this situation, the Remittance Advice will also indicate whether or not the eyeglasses are being

fabricated.

If the Remittance Advice shows that eyeglasses are being fabricated and the error that caused the claim to reject is correctable, the provider should submit a new Provider Invoice without an OPO attached.

If the Remittance Advice shows that eyeglasses are not being fabricated and the claim rejected due to a correctable error, the provider should submit a new Provider Invoice with an OPO attached.

O-235.3 QUALITY ASSURANCE

The agreement between the Department and DOC provides that DOC is responsible for monitoring the quality of the finished product. Therefore, if the ordering provider finds that the eyeglasses received from DOC do not conform to the prescription order the provider submitted or that the finished product is defective, this is to be reported directly to DOC for resolution and refabrication of the eyeglasses, if necessary.

Procedure: Contact DOC at the address or phone number shown in Topic O-235.1.

The ordering or dispensing provider will not be held accountable for the cost of replacement eyeglasses or parts when the error is attributable to DOC or to the Department.

If the ordering provider or the patient finds that the eyeglasses are not usable due to error in how the prescription was written, the ordering provider must arrange for fabrication of new eyeglasses at his or her own expense. The DOC laboratory is not to be used. Additionally, neither the Department nor the patient is to be billed.

O-235.4 REPLACEMENT OF BROKEN LENSES

If one or both lenses are broken but the frame is still usable, the lens or lenses are to be ordered from DOC by completing an OPO and a Provider Invoice containing a charge for the service fee, and sending both documents to the Department. The OPO must identify the frame for which DOC is being asked to fabricate a new lens or lenses. The new lens or lenses will be sent directly to the provider for insertion into the frame.

O-235.5 FRAME, FRAME PARTS AND REPAIRS

Except as provided in Topic O-212.5, only DOC frames are covered by the

Department. A replacement frame may be covered only when the present frame is broken and is non-repairable or has been lost.

In instances where it is evident that the repair of an existing frame is less costly than providing a new frame and when such repairs provide a serviceable frame for the patient, consideration is to be given to repairing the existing frame. New frame parts including fronts, temples, etc., are covered when used to repair an existing frame.

Procedure: If the frame that has a broken frame front or temple is a DOC frame, the part is to be ordered from DOC by completing the OPO and the Provider Invoice and sending both to the Department. The OPO should clearly identify the frame and provide relevant parts specifications. The Provider Invoice should contain a service fee charge.

If the frame that has a broken frame front or temple is not a DOC frame but the provider can furnish the replacement part, the provider completes the service and bills both the part and the service fee on the Provider Invoice. No OPO is completed or attached to the Provider Invoice.

If the frame that has a broken frame front or temple is not a DOC frame and the provider cannot furnish the replacement part, new eyeglasses (complete glasses) may be ordered from DOC by completing the OPO and the Provider Invoice and sending both documents to the Department.

O-270 HOME AND LONG TERM CARE FACILITY SERVICES

A provider may provide a covered service to a patient in the patient's place of residence (private home or long term care facility) when the patient is physically unable to go to the provider's office.

Charges may be made for the examination or for the services the provider provided at the time of a home visit in accordance with policy and procedures applicable to office services, and within the limitations and requirements specified in Topics O-270.1 and O-270.2 for services provided in long term care facilities.

No charges may be made for services provided to residents in a long term care facility by a provider who derives a direct or indirect profit from total or partial ownership (or from other types of financial investment for profit) of such facility, except:

a) for emergency services provided for acute illness, or

b) when essential treatment facilities are not available in the vicinity for short-term care pending transfer, or

c) when there is not a comparable facility in the area.

Charges may not be made for services to residents in a long term care facility by a provider who receives reimbursement from the facility for direct patient care services.

O-270.1 LONG TERM CARE FACILITY LIMITATIONS AND REQUIREMENTS - VISION EXAMINATIONS AND REFRACTIONS

Non-essential visits to residents in long term care facilities are not allowed and payment will not be made for such care. Such care includes screening services.

To be considered for reimbursement, routine vision examinations and refractions performed in a long term care facility must meet the requirements in Topic O-203.1.

All services provided by the provider to residents in long term care facilities are to be documented by the provider in the resident's record which is maintained by the facility. The record must be documented with the reason for the visit, including the name of the individual requesting the service. See also Topic O-205.

O-270.2 LONG TERM CARE FACILITY LIMITATIONS AND REQUIREMENTS - MEDICAL SERVICES PROVIDED BY A TPA/DPA CERTIFIED OPTOMETRIST

Except for emergency services provided when the attending physician is not available, an optometrist may not charge for medical services to a resident in a long term care facility unless the attending physician has made a referral with the resident's knowledge and permission.

Charges are not to be submitted for routine visits that are made without individual referrals by the attending physician. Referrals must be specific to the medical condition or need of the resident. Payment cannot be made for screening or preventive services or for routine or periodic examinations.

Visits made to residents eligible for Medicare benefits will be disallowed if determined not medically necessary by Medicare.

O-283 SURGICAL SERVICES

Reimbursement to a physician for surgical services includes the presurgical examination and complete postoperative care for a period of 30 days. Other practitioners, including optometrists, may bill for medical visits during this period only for conditions or diagnoses unrelated to the surgery. A narrative explanation of the medical necessity for such care must be submitted with each claim.